

**The Death in Custody of a prisoner
HMP Bristol – June 2004**

**Report by the Prisons and Probation Ombudsman for England
and Wales**

March 2005

This is the report of an investigation into the circumstances surrounding the death of a prisoner in HMP Bristol on 23 June 2004. The man had been unwell for some time with lung cancer and his death was not unexpected. He had chosen to remain in Bristol prison rather than go to the local hospice (St Peter's). He did, however, receive regular visits from a nurse at St Peter's. The nurse advised on appropriate respite care and pain relief medication for him.

The investigation was led by one of my colleagues. An independent review of the prisoner's medical care in prison was commissioned from the Clinical Governance Lead for Bristol North Primary Care Trust.

We would like to extend our condolences to the prisoner's family and to those touched by his death.

We would like to thank the management and staff at HMP Bristol for their assistance and co-operation during the course of this investigation.

This report contains three general recommendations. However, I would like to draw particular attention to the three other recommendations concerning good practice revealed by the investigation. Given the very difficult challenge of caring for a terminally ill man serving a discretionary life sentence, staff at Bristol demonstrated high levels of professionalism and compassion.

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Summary

The prisoner was a 62 year old man who was serving a life sentence at HMP Bristol. He died on 23 June 2004 from lung cancer. His death was not connected to the fact that he had been in prison, nor to the level of care that he received whilst in prison.

He was born in May 1942. Prior to his custodial sentence being imposed, he lived in Portsmouth, Hampshire.

HMP Bristol is a local prison that generally holds people who are on remand. Once people have been sentenced by a court, they are usually moved to another prison. Bristol does accommodate some long term and life sentence prisoners on one unit. This is the wing where the prisoner lived from September 2003 to the time of his death.

The prisoner was first diagnosed with lung cancer in 1999. In June of that year, an operation to remove the tumour was successful, but by September 2002, the cancer had recurred. At this time he was given chemotherapy and the following September a course of radiotherapy. The prisoner was told in September 2003 that his condition was terminal and that his prognosis was three to six months.

Various options were looked at concerning the palliative care of the prisoner. Staff at Bristol prison did much to explore the options that were available to him. These included transferring him to Kingston prison in order that he could be nearer his family, early release on compassionate grounds, respite care in a hospice, and moving from his wing into the Healthcare Unit at the prison. As it turned out, apart from a day visit to a hospice in Bristol, The prisoner remained on B wing within Bristol until his death.

There were no major concerns raised by the clinical review about the medical care that the inmate received. A couple of prisoners told my investigator that he had complained of chest pains shortly before his death. They seemed to be under the impression that he might have suffered a heart attack shortly before he died. The post mortem report indicates that the prisoner died as a result of a pulmonary thromboembolus (a rupturing of some arteries in his lungs), which was due to his lung cancer. The chest pains were most likely due to the size of the tumour in his lung. His heart was healthy.

This report makes three recommendations.

Investigation Process

My practice in investigations into a death from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

My colleague first visited HMP Bristol on 1 July 2004 and met with the Deputy Governor. She was given a full briefing about the circumstances surrounding his death and the current situation regarding family contacts and actions instigated by the establishment to deal with the prisoner's death. They met with a representative of the Prison Officers Association. A notice to staff and a notice to prisoners was issued by the prison, inviting anyone who might have information relating to the prisoner's death to make themselves known to the inquiry team. No one came forward from these notices.

My colleague took away with her all of the files and records relating to the deceased and then commissioned a clinical review from the Clinical Governance Lead for Bristol North Primary Care Trust. My colleague then returned to Bristol in November and spoke to four inmates who all knew the prisoner, and to governors who had been involved in some of the decisions relating to him and his care whilst in Bristol.

My family liaison officer contacted the prisoner's brother. He had some questions regarding his brother that he discussed with the family liaison officer. He specifically asked the investigator to talk to prisoners who knew his brother and to find out about any chest pains that he may have been complaining about, the day before he died. The prisoner's brother also wanted to know why the prison would have handcuffed him, had he been taken to a hospice. The third question that the prisoner's brother had concerned early release on compassionate grounds, and why consideration could not have been given to releasing him into the care of a hospice.

Background

The prisoner was brought up with three brothers and two sisters. He was musically gifted, like his mother, and learnt to play the piano at an early age. His father died when he was 9 years old, and his mother brought up the family on her own.

The prisoner came to England in 1960 and qualified as a chef. He worked as a chef and played music in his spare time. The prisoner's lifestyle as a musician meant that he spent a lot of time in pubs and clubs and he developed a drink problem. He was married twice, but both marriages broke down. He stopped drinking in 1984, after suffering a stroke.

The prisoner was convicted and given a life sentence in July 1998. The judge passed a discretionary life sentence with a tariff of eight years saying that both the pre-sentence report and psychiatric report indicated that it was not known when he would no longer be a risk to the public.

The prisoner had his first Parole Board Review in April 2003. They did not recommend him for transfer to an open prison or release on life licence. His next assessment would have been due in September 2004. The Parole Board noted that he denied the offences for which he had been convicted and hence he was unwilling to undertake some of the offending behaviour courses that were considered appropriate for him. They also recognised that, due to his medical conditions, he was unsuitable for some of the courses available to help reduce the risk of re-offending.

The prisoner had been in Bristol prison since 17 July 2003 and had worked for several months in the library. Staff at Bristol described him as polite and respectful towards other prisoners and towards staff. The prisoner was a long term smoker and suffered periodically from epilepsy and insomnia.

The Events Leading Up To The Prisoner's Death

In March 1999, whilst in Winchester prison, the prisoner had a chest X-ray. A nodule was found in his lung. He had this carcinoma of the lung excised in June of that year in Southampton General Hospital.

In September 2002, the prisoner was in Full Sutton prison near York. He had a CT scan which showed a probable recurrence of a tumour in his right chest wall. He underwent six cycles of chemotherapy, which had the effect of reducing the size of the tumours. After transferring to Bristol prison in July 2003, the prisoner was seen, in September by a Consultant Clinical Oncologist. By this time the prisoner was experiencing some discomfort in his chest. He was given radiotherapy for palliative care. The Oncologist felt that the prisoner's prognosis was three to six months at this stage.

The prison considered early release on compassionate grounds for the prisoner. They completed the necessary paperwork in November 2003. However, only the external consultant recommended release, due to the short time that he felt the prisoner had left to live. Neither the Managing Medical Officer, the Acting Senior Medical Officer, nor the in-charge Governor of HMP Bristol recommended release. Because of these negative recommendations, the application was not pursued further with the Parole Board.

A referral to a local hospice in December resulted in a member of the home care team visiting the prisoner in Bristol on 16 December. At this first meeting, she explained her role and talked to the prisoner about his feelings and how he was generally.

In January 2004, there is a note on the prisoner's record that the Principal Officer and B wing staff had raised concerns about him staying on B wing and about whether they could manage his care appropriately. Someone from healthcare spoke to the prisoner following these concerns raised by staff. She noted that he was 'very content' to stay on the wing and that he felt he could cope satisfactorily. On 10 February, he indicated to medical staff that he wanted to go to a hospice in Southampton to be near his family. Two days later the homecare team member from the local hospice visited, and a multi-disciplinary meeting was held. This involved prison medical staff and a governor. The member of homecare team explained to the prisoner that hospices could not normally admit a patient for more than two weeks at a time. This meant that the prisoner would not have been able to go directly to a hospice in Southampton, but he might have been able to go for short periods of time from a prison in that area.

During February and March of 2004, the prisoner was becoming progressively more unwell. He received visits from the homecare team member on 25 February, 10 March and 31 March. She noted that he was comfortable and managing on the wing. On her latter visit she recommended that the prisoner be given more pain relief medication. He was offered a bed within the Healthcare Unit at Bristol at the end of March but declined this move.

In April he was reviewed by the doctor, who decided that further chemotherapy treatment was not appropriate due to the fact that the prisoner had a terminal condition. B wing staff raised concerns again about the

prisoner remaining on the wing, but a healthcare entry indicates that he was continuing to refuse a bed within the Healthcare Unit.

A short term transfer to the local hospice for respite care was looked at. A bed was offered by the hospice from 20 to 23 April. Arrangements were put in place to escort the prisoner to the hospice and for prison staff to supervise his stay there. However, there appears to have been some confusion over the arrangements as regards handcuffing and the wearing of uniform by the officers. This caused the visit to be cancelled at the last minute on 19 April. The governor in the security department was under the impression that the local hospice had said the stay could only go ahead if the prisoner was not handcuffed and the staff wore civilian clothing. This was not in fact the case. New arrangements were quickly made and he was offered a two night stay on 27 April. The prisoner refused to go to the hospice on the morning of 27 April. A nurse spent an hour talking to him about the situation. She noted that he said he was 'frightened' and that he did not want to go to the hospice because he said he 'wouldn't be coming out again'.

Another case conference was held on 5 May, attended by a mixture of medical staff and prison discipline staff, as well as the prisoner. A note of this case meeting shows that the prisoner raised concerns about being handcuffed to the bed. It was explained to him that he would be handcuffed, but not to the bed, when in the hospice and that he would not be 'released' to go on his own. The group also discussed with him about looking into a transfer to Kingston prison, so that he might be able to go to a hospice near Southampton for respite care. He agreed to let the staff know what he wanted to do, once he had had time to decide. Two days later he told staff that he would like a transfer to Kingston prison to be arranged. Several steps were taken by staff at Bristol in order to try to arrange this move, but for various reasons, which are detailed later in this report, Kingston prison declined the transfer request.

On 2 June, he had a further oncology out patient appointment with the Doctor. After this he went to look around the local hospice and spoke to the member of the homecare team. Apparently the prisoner agreed, during this visit, to go to the hospice for respite care / terminal care. A subsequent visit by the home care team member on 17 June indicates the prisoner had changed his mind about going to the hospice because he could not tolerate being handcuffed or having people see him with prison staff around. A note of this meeting indicates that he was noticeably weaker than on the homecare team member's previous visit. There is another note in the prisoner's medical file that the aim should be to get him to agree to go to the prison's Healthcare Centre when a bed became available. Four days later, on 21 June, there were still no beds available in Healthcare.

At unlock on 23 June, a wing officer went around the wing and checked all inmates. He said 'Good Morning' to the prisoner and reported that he got a wave in reply. About ten minutes later, at 8:10am, the prisoner came out of his cell (B1-28) and spoke to a friend of his. About five minutes later, the prisoner asked the wing officer to get his medication for him as he did not feel able to collect it himself. The wing officer said that this was not an unusual request, and that the prisoner's mobility meant that he would often ask for

medication to be brought up to him. The wing iofficer spoke to a Nurse about this and she agreed to arrange for delivery of the prisoner's medication.

Just before 08:40 he was found on his bed by another prisoner. He did not seem to be breathing. The prisoner who found him told another prisoner what had happened. Another Wing Officer says that he shouted to her 'Gov'. The Officer rushed to the prisoner's cell, thought he was not breathing, and so immediately radioed a 'code blue' message to healthcare. On returning to the cell another inmate said to the Wing Officer that he thought the prisoner was breathing faintly. A PE Senior Officer and another Senior Officer arrived at the prisoner's cell a few seconds later. They had been downstairs in the wing office and had run upstairs when a prisoner had told them of the situation. The Wing Officer then ran off to get the resuscitation kit, as requested by the Senior Officer. As she ran down the stairs, she passed the arriving healthcare team, who were carrying with them the code blue response equipment.

The PESO said that the prisoner was lying on his bed and that within a few seconds of her arrival he gasped twice, but then appeared to stop breathing. The PESO immediately commenced mouth to mouth resuscitation and chest compressions, aided by the SO. Healthcare staff arrived shortly after and continued to try to resuscitate the prisoner. The doctor was notified by a Healthcare Officer at 08:50 that morning. A Doctor attended the prisoner's cell on B wing at 08:53 and assessed the situation. Resuscitation had been attempted for over 20 minutes. The Doctor found no pulse and on attaching an ECG monitor found that the prisoner had no electrical activity and was not shockable. He was pronounced dead at 09:05.

The Prison Response following the Death

Bristol prison has a comprehensive 'Death in Custody' booklet that is completed by the orderly officer, investigating governor and the doctor in the event of a prisoner's death. It provides detailed information including prisoner details, when and how the death occurred, Coroner information and post mortem arrangements. My investigator found that most sections of this booklet had been completed comprehensively and the document was very useful.

The prison contingency plans for a death in custody were implemented. At noon in the chapel, a hot debrief took place for all staff who had been involved. Statements from all those staff who had been involved were taken and these were found to carry an appropriate amount of detail.

A Doctor carried out the post mortem on 24 June and confirmed the cause of death to be pulmonary thromboembolus, a consequence of deep vein thrombosis, caused by lung cancer.

The prison held a memorial service for the deceased on 1 July in the chapel. The governor issued a notice to prisoners informing them of the service and invited B wing prisoners and others who knew him to attend and pay their respects. The service was well attended by prisoners.

Issues considered during the investigation

Compassionate release

The prisoner was considered by the prison for early release on compassionate grounds (under section 30 of the Crime (Sentences) Act 1997). The general principles governing early release on compassionate grounds are:

- the release of the prisoner will not put the safety of the public at risk;
- a decision to approve release would not normally be made on the basis of facts of which the sentencing or appeal court was aware;
- there is some specific purpose to be served by early release.

The rules governing early release go on to say that where early release is to be considered on medical grounds, the prisoner should be suffering from a terminal illness and likely to die soon (guide is within the next three months). The Secretary of State (via the Parole Board) must also be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison.

The documentation was completed by staff at Bristol prison in November 2003. Neither the Managing Medical Officer, Acting Senior Medical Officer nor the Governor of HMP Bristol felt able to recommend release at that time. Their reasons were that the prisoner's condition was not so severe as to make him incapable of committing further criminal acts. The governor stated that the prisoner had not completed any offending behaviour courses which might have reduced his risk, and he was continuing to deny the offences of which he had been convicted. The consultant in Clinical Oncology at Bristol Haematology & Oncology Centre who looked after the prisoner, did support the early release application due to the fact that he thought the prisoner had only a few months left to live. He was, however, the only one who did, and was not aware of the nature of the prisoner's offence.

The probation team stated in their report that the prisoner's sister had poor health and would be unable to look after her brother directly. It was stated that she would offer support to him if he was released near her home in Southampton. The report did not go on to say where, if any, suitable accommodation had been found. It would not have been possible for the prisoner to have been admitted to a hospice on a long term basis at this point. Hospices can normally only accommodate people for short periods - around two weeks at a time for respite care.

Due to the fact that there was no real support for the compassionate release application, the papers were not sent to the Parole Board for consideration. This seems reasonable, given the fact that there was a negligible chance of the application being successful at this time.

I am disappointed, though, that there does not appear to have been any consideration given by the team at Bristol for early release on compassionate

grounds in the Spring of 2004 when the prisoner's condition was clearly deteriorating.

Transfer to Kingston Prison and a Hospice in Southampton

On 7 May the prisoner decided to apply for transfer to Kingston prison. His aim in doing so was to be able to go from Kingston, to a hospice near to his relatives in Southampton.

Healthcare staff at Bristol responded very promptly to this request. On that same day arrangements were started. The homecare team member at the local hospice, was asked to recommend a hospice in the Southampton area and the Bristol doctor wrote to the doctor at Kingston in order to inform him of the prisoner's situation.

On 24 May the lifer governor at Bristol wrote to the Healthcare Unit at Bristol informing them that the lifer governor at Kingston had told her that they were unable to take the prisoner on transfer. My investigator spoke to a Governor and asked her the reasons why the transfer did not go ahead. She said that whilst the member of homecare team was happy to contact a hospice in Southampton, she could not actually liaise on their behalf with the prisoner, and that a new relationship would have to be built up with staff at the Southampton hospice. There seemed to be uncertainty over how long this process would take, and whether the offer of a stay in the hospice would be forthcoming in time for the prisoner to take advantage of it. Clearly, if the chance of the prisoner getting into the hospice in Southampton was diminished, there was no purpose in the transfer to Kingston going ahead. The main concern expressed by Kingston prison was in relation to the fact that all of his care, since July 2003, had been provided by the medical team at Bristol prison and the surrounding hospitals. They felt that transferring all his care at an advanced stage of his illness to a completely new area would not be sensible or in the best interests of the patient. Kingston do not have an in-patient facility nor 24 hour nursing cover. The Governor also said she seemed to recall that the hospice that the prisoner wanted to go to, was not actually the nearest hospice to Kingston anyway, and that there might have been further complications in arranging a bed at an 'out of area' hospice.

The Governor told my investigator that the prisoner had 'swung' between wanting to go to Kingston and being completely against it. This ties in with what some of the prisoner's friends told my investigator when she spoke with them on B wing.

I can find no reason to criticise either Kingston or Bristol for their decision in May, not to pursue a move for the prisoner any further.

Conclusions & Recommendations

Bristol prison cared for the prisoner to the best degree that is possible, within a prison setting. The management and staff team were sensitive to his needs and wishes and took all reasonable steps to accommodate them.

The regular visits and expert advice about medication from the homecare team member, from the local hospice, is to be particularly commended. These visits commenced in December 2003 and continued on a regular basis until the prisoner's death. The homecare team member also attended several case reviews organised by the prison to discuss the management and care of the prisoner and the options available to him.

The prisoner clearly had several changes of mind about whether he wanted to stay in Bristol prison on B wing, move to the healthcare unit, attend the hospice in Bristol for periods of respite care, or transfer to Kingston prison. What is also apparent, however, is that he wished to be nearer to his family so that they could visit him. Sadly, this was never arranged. Bristol staff did take several steps to organise a transfer to Kingston prison but the reasons for not going ahead with the transfer were reasonable in the circumstances.

The next best option, after a transfer nearer home, would have been for the prisoner to be cared for in the local hospice for short periods when a place was available. The first opportunity for the prisoner to stay in the hospice was organised in April, but he declined due to the fact that he would have been handcuffed to staff wearing uniform. I do not think that Bristol prison were unreasonable in stipulating that a stay in hospice at this time would have involved being handcuffed. The prisoner was still mobile in April and the protection of others in the hospice and the public generally were considered to be of paramount importance.

The prisoner agreed to go and visit the hospice, prior to deciding whether or not he wanted to stay as a patient, in early June. On the member of homecare's next visit in mid-June, the prisoner had changed his mind again about going to the hospice as he did not want to be handcuffed. The governors at Bristol whom my investigator spoke to about the prisoner told her that their decision was that he would have been handcuffed initially on arriving at the hospice, but that a later risk assessment might well have indicated that there was no continuing need for them. This decision was also reasonable and the prisoner was made aware that the handcuffing issue would be regularly reviewed. One of the governors seemed to think that it was not just the handcuffing issue that made him decline the hospice, but his fear about dying when he went to one.

Concerns were expressed by the staff on B wing about the prisoner continuing to live on the wing, as he grew progressively more unwell. The prisoner was periodically offered the opportunity of moving to the Healthcare Unit within Bristol, but decided each time he wanted to stay on the wing. The prisoner's friends were on B wing and he felt more comfortable with them and

staff he was familiar with. Bristol took an understanding approach to his location in the prison and did not seek to enforce a move to a place where he would not be happy. Several of the prisoners said that nursing staff visited the prisoner on an almost daily basis and that arrangements for his meals and medication were made as necessary. I do not think that the prisoner was disadvantaged by remaining on B wing instead of going to the Healthcare Unit.

The first two recommendations are from the clinical review carried out by a Doctor.

National

Recommendation 1 - There was a short delay in the initial referral. Best practice, in line with the cancer care pathway, would advise that any haemoptysis in a patient over 50 who is a smoker, should have an urgent referral for a chest X-ray.

The ultimate goal of the government is to offer patients a maximum of a one month wait from a urgent referral for suspected cancer to the beginning of treatment.

Recommendation 2 – Bristol prison medical team should give consideration to ‘resuscitation policies’ being put into place for certain patients. It was not in the prisoner’s best interests to have been resuscitated. Although this would be easy to develop, it would be complex to implement due to the many different staff and disciplines involved.

Prisons should develop clear policy statements about the resuscitation of prisoners in accordance with national guidance on consent to treatment.

Recommendation 3 – The Prison Service’s Safety Custody Group should remind governors that Applications for Early Release on Compassionate Grounds should be considered by prisons at regular intervals whilst they are caring for someone who is terminally ill.

Recommendations re: Good Practice

The multi-disciplinary case conferences held to discuss all aspects of the prisoner's medical and general care with him were an example of good practice.

The 'Death in Custody Booklet' produced by HMP Bristol provides a useful summary of relevant information.

The early involvement of nursing staff from a local hospice for terminally ill cancer patients is good practice. It ensures that patient support and appropriate advice on palliative care medication is given.